Primary Care: The Urban Hospital's Role

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In the best of all possible worlds, solutions to the problems of delivering high-quality primary care to inner-city residents would probably involve hospitals peripherally, if at all. Ideally, other mechanisms for delivering primary care, from private group practices to freestanding community health centers, might be preferred. The track record of hospitals in organizing and delivering primary care services is, at best, mixed, and there are powerful structural limitations on the capacity of hospitals to do what is right in primary care. Moreover, hospitals that are located in the communities most in need of primary care services are precisely those operating under the greatest fiscal stress, with the fewest available resources to invest in primary care development.

Nonetheless, if we are to begin rebuilding the primary care infrastructure in our inner cities over the next decade in order to give those communities some semblance of the services they need, hospitals will have to do it because no one else will. More precisely, other institutions or organizations that make the attempt will find themselves highly dependent on hospitals if they are to succeed. While hospitals are indeed characterized as having many significant limitations as potential organizers and deliverers of primary care services, much can be done to increase the likelihood that they will succeed.

Missing Links

The essential element in providing primary care services in inner-city neighborhoods, or anywhere else, is a supply of competent and interested health professionals—physicians, "physician extenders" (such as nurse practitioners and physician assistants), nurses, pharmacists, and others. These professionals can work in individual or group practices, in community health centers or similar freestanding clinics, in facilities operated by prepaid plans, or a number of other possible settings. The shortage of such professionals is the principal reason for the inadequacy of primary care services in many inner cities, and, for a variety of reasons, that shortage is getting worse.

Extensive experience in a number of communities has demonstrated that such professionals can be recruited to work in inner-city primary care settings provided there is an adequate financial base, an appropriate physical setting, opportunities for professional interaction and educational experiences, and ties to a good hospital. However, start-up capital for freestanding physician practices is scarce, and most community health centers and freestanding clinics have traditionally relied on government subsidies that are increasingly difficult to obtain. Even when financing is available, professional isolation and especially problems with admitting privileges have crippled such facilities' attempts to retain medical staff. The experience of the 1980s with efforts to enroll Medicaid populations in health maintenance organizations or other managed care arrangements suggests that such enrollment efforts for primary care services are not likely to be successful in most communities in the foreseeable future. There has been some success, but simply not enough people will be enrolled to make a major dent in the primary care system.

Hospital Assets

In the development of primary care services, hospitals thus start with the capacity to develop appropriately supportive relationships between the hospital and primary care providers. In addition, they possess some of the infrastructure—laboratories, radiology, billing and medical records capabilities, malpractice insurance—which is so difficult and often impossible to reproduce economically on the smaller scale of a primary care setting. Hospitals already constitute major mobilizers and employers of health professionals; even if the hospital has an inadequate cadre of individuals expert or interested in primary care, it at least has a critical mass of nurses, administrators, other health professionals, and physicians. In many inner-city communities, hospitals are the only institutions that have a repository of substantial managerial and internal educational capabilities as well as the capacity to amass and target the efforts of a large number of people with different skills and occupational backgrounds.

Most critical, the hospitals already have the patients. Emergency rooms and clinics in inner-city hospitals are the de facto family doctors for large parts of the population. While their cur-
rent services lack continuity, provider familiarity with patients, and patient convenience and amenity, hospitals already are in the primary care business to a greater degree than anyone else, and they have the patient base from which to build a better system.

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Hospitals are becoming increasingly motivated to restructure their system, since the current system is one with which everyone is unhappy. Hospitals don't like overcrowded emergency rooms filled with people who don't meet their trauma surgeons' or cardiologists' definition of emergency cases. They don't like losing the amount of money that their emergency services are costing them. They especially don't like losing money on what they and others perceive as a second-rate service. At the same time, hospitals recognize that their patients are also unhappy with this system, its long waits, inadequate physical facilities, and lack of continuity of services.

While economic issues remain the major barrier to development of hospital-based primary care services, hospitals do have some advantages over other providers or potential providers in financial management. They employ, or can employ, capable financial management professionals and systems; they have working capital—often not enough for hospital purposes, but much more than that available to many other organizations—and they generally have access to credit and to debt.

Hospital Liabilities

Hospitals also have significant liabilities in attempting to develop primary care services. To start, primary care is not their business. Most hospitals continue to be concerned primarily with high-technology inpatient services. The hospital power structure, economic structure, and managerial system, as well as the dynamics of most medical staffs, dictate that direction. Hospital mores reflect, unsurprisingly, the tendency in our society to value the technologically intensive, dramatic, and sophisticated services more than the apparently humdrum provision of routine care. High-technology inpatient services are what hospitals do best; those are the services around which they compete and which establish their identities. Because of potential conflicts between doing a first-rate job of community-based primary care and a first-rate job of tertiary high-technology inpatient services, it is not surprising that more often than not the inpatient services wins.

In many ways the provision of primary care services is a fundamentally different business from the provision of inpatient services. It requires different types of management systems and different kinds of managers. Most importantly, primary care services require a different orientation and philosophy than those activities on which most hospital managers have based their careers. Thus, the customary practice in many hospitals has been to appoint to ambulatory care positions either junior managers right out of training programs or the most senior managers who aren't yet ready to retire, while keeping the "important" services like cardiac surgery or new imaging equipment under the jurisdiction of those who are still on the fast track.

Moreover, even with the best of managers, hospitals often have trouble building and operating what might be described as user-friendly or patient-friendly systems for the provision of outpatient services. Such "user friendliness" is not solely a matter of image where inner-city primary care services are involved; without it, patients won't come for services, those who do come won't come back for needed revisits, and reliance on the emergency room for nonurgent evening and weekend services will persist. However, hospitals have traditionally been extremely friendly to their "users"—the physicians—by organizing the routines of their services, physical facilities, and schedules to maximize physician convenience, often at the expense of patients or potential patients.

Hospital involvement in primary care raises complex issues of governance, issues of a sort that do not bedevil other potential primary care providers. Hospitals tend to be large, complicated institutions, and their governance is intrinsically complicated most of the time. Yet effective inner-city primary care requires a degree of connectedness and responsiveness to local communities that may be particularly difficult for many hospitals. The people who have traditionally been responsible for the oversight and governance of hospitals, and who are central to its ability to tap both governmental and private sources of support, are frequently unlikely to live in, to be politically connected to, or to be viewed as representative of the communities they are trying to serve. Bridging that distance can be accomplished, under the right set of circumstances, but doing so is often neither easy nor enjoyable.

Dollars and Cents

All of these other obstacles notwithstanding, the major problem hospitals have in the provision of primary care services in inner-city communities is economic. Only a few hospitals in the United States can currently avoid losing money on primary care delivery. Those are in states where subsidies for uncompensated care run through a hospital rate-setting system are generous enough and can be applied to hospital-operated or -affiliated outpatient services. Elsewhere, inner-city primary care means serving Medicaid recipients and the uninsured, and in an increasing number of states Medicaid reimbursement for outpatient services is extremely inadequate and appears positive only in contrast to no reimbursement at all.

The reimbursement problems are complicated by the difficulty hospitals have in providing primary care inexpensively. In New York City, for example, it costs hospitals 20% to 25% more to provide a primary care visit and associated ancillary services than a freestanding clinic, and private physicians' charges are lower still. For years it was believed that hospital outpatient costs appeared so high because of cost allocation...
practices, although the incentive to do so has actually increased in recent years since the advent of the Medicare prospective payment system, while the relative pricing differential does not appear to have changed dramatically. A more plausible explanation is that hospitals have a great deal of standby and overhead capacity, particularly in their emergency services, associated with operating 24-hours a day, seven days a week. Hospitals also tend to be more generous, and perhaps less demanding, employers of nurses and clerical and laboratory personnel compared to private physicians or freestanding clinics, and they are certainly required to meet more stringent requirements for their physical facilities—although hospitals can generally get their capital less expensively than other primary care providers.

Providing high-quality primary care to a population with low income and high disease prevalence is not cheap. Ambulatory care may be less expensive than other forms of care, but that does not mean that it’s inexpensive, although the major payers insist that it should be.

Looking Forward

The critical step in hospital involvement in primary care services is the institutional decision to take on these challenges. For some, the decision will be dictated by a perception of mission; for others, it will be seen as the key to a survival strategy; the potential motives are numerous. Once the institutional commitment is made, the financial problems can then be addressed.

Under the Omnibus Budget Reconciliation Act of 1989, state Medicaid programs are now obligated to make supplemental payments of some kind to disproportionate share hospitals, but whether those payments will be at all adequate to subsidize primary care services is a question that will have to be fought out in every state legislature. More targeted subsidies are becoming available for prenatal care and possibly also for services to patients infected with the human immunodeficiency virus. Other new, targeted subsidies may well follow. Community philanthropy cannot provide nearly as many dollars as these public sources, but it has probably not been adequately tapped over the last decade or two, when the third-party reimbursement environment was more favorable, and hospitals are gradually rediscovering the potential of such philanthropy for subsidizing services to the poor.

In developing and implementing all of these measures, hospitals will need to take the lead. Certainly, faced with many legitimate competing demands, potential funders will not seek to channel funds to primary care services if the potential providers of those services aren’t creatively, visibly, and actively interested. Experience suggests that hospital commitment and initiative is a necessary condition for the development of new funding sources. Such interest and initiative may not always succeed at developing such funding sources, but the development will not take place without them.

Considering the variety of inner-city communities and the hospitals located in or near them, the specific details of hospital-based primary care services are sure to vary considerably between institutions, as they should. Those services will, to varying degrees, involve a web of relationships with other organizations, providers, and community groups and will be financed and organized in a variety of ways. However, existing models suggest that with sufficient quantities of goodwill, energy, commitment, and, above all, patience, hospital-based primary care will not only survive but thrive.

It can be done, if the institutions want to do it, as I obviously believe they should. Since we have no other options, we may as well make the best of it and enjoy the process as much as we can.